

## ORIGINAL ARTICLES

## ADEQUATE INSTITUTIONAL CARE OF THE TUBERCULAR.\*

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Our great object in this campaign against tuberculosis is twofold, (1) to take care of the cases which are tubercular, and (2) to prevent others from becoming infected. While these two objects may at first thought seem to be sufficient unto itself, they are in reality one and the same thing. For if we properly and adequately take care of our tuberculous of to-day, prevention for to-morrow will have received its greatest help.

Tuberculosis is certainly a disease which needs institutional care for a part of its course, if taken early, and for a longer period if the disease is allowed to become a deep-rooted infection. Adequate institutional care then, means enough sanatorium beds to provide for the cure or arrest of the incipient and favorable cases, and comfortable hospital beds for the advanced and rapidly progressing cases.

Taking it for granted that everyone is in favor of more institutional care from a medical and sentimental viewpoint, let us briefly consider the purely economic reason why we should do all in our power to protect future generations against the ravages of this disease. Locke and Floyd<sup>1</sup> in 1913 gathered together very interesting data on the economic loss caused by 500 consumptives. First, what was the loss in wages, that is to themselves, during their period of complete disability? This amounted to \$426,039. I will not burden you with the way in which this sum was computed, but would refer you to their article. Next, what did it cost the state to care for them during this period—the actual care, not taking into consideration the cost of building the hospital? This amounted to \$73,984; or \$500,000 represented what they had lost in wages and what it had cost to board them. This also makes no reference to the public and private aid that many received before they were completely disabled. The total weekly income of the families, where there were families, was reduced from \$6807 to \$3055. The total number of families without any income after the disablement of the patient was 161, and this represented a total weekly loss of \$1877.75. Now if we take the figure Fisher says represents the minimum average value of each life cut off by tuberculosis which is the capitalized value of his earnings, to be \$5,600, we have a total loss in the 244 cases which died of \$1,366,400. This figure added to the previous amount lost in wages and spent on care of these 500 patients amounts to \$1,866,400. This group of 500 represents but a very small unit when we consider that here in San Francisco there are about 8-9,000 tubercular cases, and in the state about 52,000. The economic loss in money is surely an appalling amount. Newsholm has shown that the greatest drop in

death rate took place in those communities where the advanced cases—the greatest menace—were isolated. Does it not seem, from all this, that our state should expend even more money than it does, where prevention means avoiding such an economic loss?

The question at once arises as to what cases shall be provided for by the state. The policy of one of the states<sup>2</sup> is as follows: to care for (1) state wards—those in the state asylums or prisons who have tuberculosis; (2) those of foreign birth who have no legal settlement in any municipality of the state, and (3) early cases who best can be treated according to the modern sanatorium methods. To these classes a fourth class might be added in which the state and federal government will co-operate—the migratory indigent with tuberculosis. The aid received from the government on these cases should be in the form of a subsidy, allowing \$3-\$5 per capita per week for the care of all transient cases in hospitals or sanatoriums. California bears her full share if not more than hers, in the migratory class of tubercular individuals and such aid from the federal government would enable much more intensive work to be done. Advanced cases can best be cared for in local hospitals, supported chiefly by local funds. The state<sup>3</sup> may help the localities by granting them a lump sum each year—a thing which might easily become the prey of politics—or it might subsidize the local hospitals, appropriating \$3-\$5 per capita per week. This would encourage the building of local hospitals and stimulate local interest. The former plan is in use in Pennsylvania, Rhode Island, Connecticut and Maine. The subsidy method is practised in Massachusetts and Minnesota which provide \$5 per capita per week, Washington and New Jersey \$3 per capita per week, and Wisconsin, which provides a sum not to exceed \$5 per capita per week. Minnesota also subsidizes the building of county hospitals, paying one-half the cost of building and equipment, this amount not to exceed \$50,000 a year. If there were a *central examining board* through which all cases for sanatorium treatment should pass, and which had charge of the patients while in the sanatoriums much more intensive treatment could be carried on for those who were progressing favorably. If this were not the case many beds in the sanatorium might be occupied by unfavorably progressing cases to the exclusion of others who might be profiting more fully by such expensive care.

Institutional care is not complete until we have dispensaries and visiting nurses' associations which, in the first place, may act as feeders for the institutions; to bring in members of the family who have been exposed to tuberculosis; to educate those in the homes as to hygiene, etc., and finally care for the cases as they are discharged from the sanatoriums in a complete follow-up system.

A further responsibility of the institutions is to find a proper position for the discharged healed patients. In a climate where there are no extremes of heat and cold, such as California, much can be done out-of-doors. A survey of the fruit business<sup>4</sup>

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shows that their season lasts from the middle of March to the end of November. Many observers<sup>5</sup> on this point advise the return of the patient to his former occupation, provided this is not a definitely harmful one. They believe that the attention should be paid to the time the patient is not at work; the necessity of getting to bed early; obtaining as much rest during the day as possible; plenty of good food, etc. There are other types of work which might be mentioned but I will not go into detail on this subject.

So, the well rounded complete institutional care should include, the finding of the early cases, bringing them together in the local hospitals where their condition may be so studied that those with favorable outlook shall receive the most intensive treatment, and finally finding positions for the discharged healed cases.

Finally let me state the approximate number of beds,<sup>6</sup> public and private, that a few states had for tuberculosis patients in 1913:

State	Free beds	Charge beds	Total	Population 7 1910	1913
Washington .....	260	32	292	1,141,990	1,344,686
Wisconsin .....	144	250	394	2,333,860	2,419,898
Minnesota .....	258	298	556	2,075,708	2,181,077
Connecticut .....	900	50	950	1,114,756	1,181,793
New Jersey .....	581	385	966	2,537,167	2,749,486
California .....	641	620	1261	2,377,549	2,667,516
Massachusetts .....	1611	1136	2747	3,366,416	3,548,705
New York .....	6579	1804	8383	9,113,614	9,712,954

Let us hope that the future for California in this great work will be the development of public opinion, which in turn will result in such legislation that our incipient and advanced cases will receive the adequate institutional care that we must have to save future generations from tuberculosis.

#### References.

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3. Tuberculosis Legislation in the United States. National Association for the Study and Prevention of Tuberculosis. New York, 1915.
4. California Fruit Canners' Association.
5. Alfred Worcester, 1909: Suitable Employment of Tubercular Patients. Employment of Arrested Cases of Tuberculosis. David Lyman, Wallingford, Connecticut.
6. Tuberculosis Directory, 1911, with supplement to 1913.
7. Department of Commerce, Bureau of the Census, Bulletin 122. Estimation of the population 1910, 1911, 1912, 1913, 1914.

## COURSE OF FRESH SYPHILIS AS TREATED BY THE NEWER REMEDIES.

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Salvarsan and neosalvarsan, the only two newer antisyphilitic remedies to be seriously considered, have modified the course of fresh syphilis in so far as it is always possible to shorten considerably the duration of the primary and secondary manifestations of the disease. The great advantage to be able to reduce the time of actual suffering, eventual disfigurement and chiefly of the disastrous period of high contagiousness, however, is in a great number of cases partly offset by the unfortunate circumstance that an easily obtained initial success inspires most patients and—sorry to state—also many physicians with a false sense of security.

Upon a leaflet of instructions for patients afflicted with syphilis, which I had printed shortly before the first publications about salvarsan, there

appeared a paragraph saying: "Proper treatment, extended over a long period, and never less than three years, is the only safeguard."

After having taken respectful, though skeptical, notice of the first enthusiastic German reports, and principally after the first personal experiences with salvarsan, I began to hope that the period of the necessary "proper treatment" could be considerably shortened, and my advice of "never less than three years" modified.

But so soon as at the forty-second Annual Meeting of the California State Society, Del Monte, April, 1912, I was able to report that: "Salvarsan alone may be able to cure syphilis; it does it, however, in exceptional cases only, and even in those we very seldom can be sure of it."

The newer remedies following so closely the discovery of the spirocheta pallida and the Wassermann reaction have taught us amongst other things that: "watchful waiting" in fresh syphilis is a crime, and further that when we are called upon to give a prognosis we must divide our patients in two classes: those that will follow proper instructions, and those who either will not follow proper instructions or are following improper instructions.

In the pre-salvarsan period just as well as since, I personally have never seen a case of central-nervous syphilis in any of the patients in the first class; many in the second.

Forty-three years ago Bäumler pointed out the danger from a too early cessation of the treatment of syphilis, and argued that "the virus may be proliferated anew in some remaining local deposit, and again infect the fluids." And to-day, after all that we know of syphilis so many patients are still told by their physicians that what they need is "an" injection of 606. Were it not for the dire consequences it would be laughable.

The syphilitic patient is entitled to the full truth like any other patient, and must know that safety lies in energetic treatment with salvarsan, neosalvarsan, and last but not least with mercury until all symptoms have disappeared and a constantly negative Wassermann reaction is obtained. Even after this result is gained, careful watching must not be neglected.

The manifestations of fresh syphilis as treated by the newer remedies alone are shortened by energetic treatment, but when either the newer remedies, the old ones, or even the combined treatment are used spasmodically and insufficiently, the symptoms may at first be influenced brilliantly, but late secondary, early tertiary symptoms and brain syphilis are of too frequent occurrence to be looked upon as accidental.

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